PATIENT EDUCATION IN PRIMARY CARE:
KEY TO ACTIVE VETERAN PARTICIPATION

Volume II Issue 3 **January 1999**
Published by the Office of Primary & Ambulatory Care and Office of Employee Education Patient Education program

WELCOME to our new resource for patient education and primary care![1]

- WHAT IS IT? The purpose of this tool is to provide a mechanism to help meet the challenges of incorporating effective patient teaching into primary health care.
- WHO IS IT FOR? VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decisionmakers

INCREASING CONTINUITY OF PATIENT EDUCATION IN PRIMARY CARE

Continuity is a growing concern for all health care providers, given the shortened lengths of stay, the increasing number of care delivery sites, the chronic nature of most conditions and the extent of self-management that patients and their significant others are asked to accomplish. System wide strategies to maintain continuity of education from inpatient to outpatient, among outpatient clinics, and from outpatient to home include the following:

- Interdisciplinary collaboration
- Electronic documentation (see related article in this issue)
- Institution-wide teaching protocols or pathways
- Consistent content for printed and other teaching materials
- Strong linkages with community referral organization

For specific patient populations, another strategy is to identify one or more clinicians who provide follow-up/case management to groups of patients with common conditions. They also often work with other disciplines to coordinate care and education across the continuum.

For example at the New York VA, Noreen Haren, RN, is one of two HIV advanced practice nurses who have responsibility to teach HIV/AIDS patients about their increasingly complex medication regimens in collaboration with the infectious disease physician, the pharmacist assigned to the HIV clinic, a nutritionist and social worker. One of her major strategies is to work with individual patients to help them devise a schedule that best fits their daily routine, using stickers with actual pictures of each medication

See **INCREASING CONTINUITY,** *page 2*

[1]**This publication may be duplicated for dissemination in the VA.**

TABLE OF CONTENTS:

INCREASING CONTINUITY

Continued from page 1

to prepare a visual guide to the regimen. Pill boxes and reminder beepers are provided to those who may need extra help in organizing and remembering to take medications. Ms Haren initiates teaching with inpatients and makes sure they know that she will see them in the outpatient clinic. She also gives her phone number to each patient in order to be available in between clinic visits to address questions or concerns. Finally, she may also initiate calls to patients at home, especially if they have missed an appointment. *Contact: Noreen Haren, RN, HIV Clinical Specialist, NY VAMC, COM 212/951-3457; FTS 700/662-3457.*

At the Salem, Virginia VA, a Case Management Program for the Chronically Recidivistic Population has been established to address the needs of patients with at least one psychiatric diagnosis and who have had 3 or more admissions to acute psychiatry in one year. The program social worker, Lisa Bradford, provides individual and group counseling, and contacts patients if appointments are missed. She and the clinic nurse do home visits weekly so that each of these high risk patients is assessed every 6 weeks to 3 months in their homes. No medical care is provided during these visits; however, the clinicians assess the living situation, the medication regimen, as well as safety, food availability and general organization of the home. During later clinic appointments, this assessment then becomes the basis for education on medication, safety issues (e.g. regarding smoke detectors or other hazards such as scatter rugs), and other referral needs. Clinical staff are also regularly available to respond to patient telephone calls. Comparison of FY 1997 and 1998 data for the 25 veterans enrolled in this program showed a drop in bed days from 1344 to 888 (a 34% decrease) and a $159,000 cost savings in care related expenses. While some of these benefits may be due to other changes in the system, staff believe that high interdisciplinary support for this program, the emphasis on building better therapeutic relationships, and staff availability to assist high risk patients address ongoing care management problems have been major contributors to these improvements. *Contact: Lisa Bradford, MSW Clinical Social Worker, Salem VAMC, COM 540/982-2463 Ext 2529), FTS 700/937-2529.*

At the New York City VA, the diabetes team (nurse practitioner, a nurse educator and a dietitian all of whom are Certified Diabetes Educators as well as a pharmacist and endocrinologist) has been investigating the efficacy of patient self-monitoring of blood glucose. As hypothesized, they found that monitoring alone is not the answer to improved diabetic control; rather there are a series of patient skills that are important to develop through step-by-step teaching and telephone follow-up. The word MAMA became the code for clinicians' diabetic care: Monitor, Assess, Medicate, Adjust. First the nurse educator works with the patient to make sure that he or she is independent with diabetic self-care skills including blood glucose monitoring. This may involve having the patient come back several times to demonstrate the skills. Then the nurse practitioner can prescribe medications and adjust them based on the monitoring values validated through laboratory tests. The dietitian also schedules visits to teach diet and basic exercise. The frequency of ongoing blood glucose monitoring is kept to a minimum in light of infection control issues and based on the data required to get a patient to and maintain a controlled state. In the final analysis, it was the patient's conscious decision about the regimen to be followed and his or her ability to follow an established regimen that had more effect on the level of control (as measured by hemoglobin A1C) than the actual frequency of monitoring. *Contact: Nancy Reilly, Nurse Practitioner, NY VAMC, COM 212/686-7500, Ext 4002; FTS 700/662-4002.*

HOW DO WE KNOW PATIENT EDUCATION WORKS?
COUNSELING TO PREVENT HIV/STDS

The purpose of this randomized controlled trial was to compare the effects of two interactive HIV/STD counseling interventions with didactic prevention messages typical of current practice. A total of 5758 heterosexual, HIV-negative patients aged 14 years or older who came for STD examinations at 5 public STD clinics were included. Group 1 received 4 interactive counseling sessions, Group 2 received 2 brief interactive sessions, and groups 3 and 4 received 2 brief didactic messages. Through the 12 month study, 20% fewer participants in each counseling intervention had new STDs as compared with those in the didactic messages groups. At the 3 and 6 month follow-up visits, self-reported 100% condom use was significantly higher in both counseling arms as compared to the didactic groups. The four session enhanced counseling and the much shorter 2-session brief counseling had equivalent STD reduction.

Lamb, M.L. et al. (1998) Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. JAMA. 280: 1161-1167.

HEAVY DRINKERS AND ABSTAINERS HAVE HIGHER MORTALITY RATES THAN MODERATE DRINKERS. New research confirms a U-shaped relationship between alcohol consumption and mortality, psychological distress, self-rated health and limiting illness. While it appears that the negative impact for abstainers is NOT related to their earlier heavy drinking, the explanation for this phenomenon has not yet been clarified. For example, does moderate drinking have a truly protective effect or do abstainers and heavy drinkers share common risk factors?

Power, C., Rodgers, B., and Hope, S. (1998) U-shaped relation for alcohol consumption and health in early adulthood and implications for mortality. The Lancet. 352:877.
Thun, M.J., Peto, T., and Lopez, A.D.(1997) Alcohol consumption and mortality among middle-aged and elderly US adults. New England Journal of Medicine. 337:1705-14.

PATIENT EDUCATION/PRIMARY CARE PROGRAM NOTES
Using Quality Improvement Data to Enhance Patient Education

To meet JCAHO standards and patient care goals, clinicians and educators are concerned both about the need to monitor the effectiveness of their initiatives and how to do it without having to collect substantial amounts of new data. Yet they may be overlooking pertinent data and expertise in their Quality Management Departments. Carol Maller, Patient Health Education Coordinator at the Albuquerque VA has found that she can access a wealth of useful data relevant both to preventive counseling/screening and chronic disease services because of the mandatory External Peer Review Process (EPRP). For example, from June to September 1998 a chart audit of nine preventive services showed more than 85% compliance for administration of influenza and pneumococcal vaccinations, counseling regarding tobacco use and tobacco cessation, and screening for alcohol use and

See **USING QUALITY IMPROVEMENT,** *page 4*

USING QUALITY IMPROVEMENT

Continued from page 3

cervical cancer. Colorectal screening at 69%, breast cancer screening at 80% and counseling regarding prostate cancer at 81% were identified as the areas that need further intervention. Additional data collected regarding chronic disease counseling showed that exercise and nutrition counseling for obese patients and those with hypertension were completed for over 85% of these patients, while documentation of correct meter dose inhaler use for COPD patients reached only 42% of eligible veterans, thus identifying another challenge for further problem solving.

Additionally, the Patient Education Unit Liaison team has been collecting performance improvement data to monitor the evolution of the Coumadin teaching program. Previously, patients discharged from the inpatient units on Coumadin were referred to an outpatient-nurse-run Coumadin Clinic for monitoring; however, upon arrival in the clinic they were not at all prepared to monitor their medication and symptoms. First a slidetape was developed for inpatients, then a video tape and more recently a complete Coumadin Kit including a home video, pill dispenser, and pamphlets to be distributed at discharge. At baseline (March-June 1997), 60% of patients surveyed stated that they had been given the kit. As part of the quality improvement process a publicity campaign was initiated to promote awareness of the availability of kits to staff; a change in medical center policy also assigned responsibility for discharge instruction to a designated pharmacist. Data collection is currently in progress to assess whether these interventions have had a positive effect.

Contact Carol Maller,RN, MS, Patient Health Education Coordinator, Albuquerque VAMC, COM 505/265-1711 ext. 4656; FTS 700/572-2400 ext.4656.

Electronic Documentation has JCAHO, Continuity of Care Benefits

During the process of integrating the Waco, Marlin, and Temple medical centers and the Austin (TX) Outpatient Clinic into the Central Texas Veterans Health Care System (CTVHCS), patient education staff chose to build upon an earlier commitment by several sites to the electronic record and establish templates for patient education progress notes right from the beginning. Based on JCAHO standards and those established by the system's patient education committee, it was decided that the following information should be documented for each episode of patient education: assessment of readiness to learn, goal of the teaching, specific content taught, who was taught, method used for teaching and patient response to teaching. Given that a basic assessment of the veteran's ability to learn, and barriers to learning should be completed for all veterans, it was further decided that for primary care patients this assessment should be completed at the time of the annual physical.

Currently templates for assessment, repetitive teaching situations and specific topics of instruction have been developed and entered in the electronic progress notes. Such templates have been developed for all services to use, for all established patient education programs and for many specific topics that are taught in primary care. (See the most commonly used template in primary care—the Exit Interview). All of these titles are grouped together under the classification of < Education > in the progress note set up. Wherever the veteran is seen (inpatient or outpatient) the patient education templates are used for documentation of the educational interventions. If more than one discipline is involved in the assessment/teaching documented on the template, the person who originates the note can identify signers to the note.

See **ELECTRONIC DOCUMENTATION,** *page 6*

PATIENT EDUCATION IN PRIMARY CARE:
Volume II Issue 3 KEY TO ACTIVE VETERAN PARTICIPATION JANUARY 1999

WHERE ARE YOU AND YOUR PRIMARY CARE TEAM IN PATIENT TEACHING?

A SELF-DISCOVERY QUIZ

(Reprinted from March 1997 Issue)

Answer the following questions with your Primary Care team to discover your patient teaching score. Guidelines for scoring are at the end of the test.

1. I am completing this survey
   a. by myself (What team?)
   b. by myself—other team members don't do health teaching
   c. with one other member of my primary care team
   d. with multiple members of my primary care team

2. Teaching materials such as videos or pamphlets can help in teaching patients. Your primary care team
   a. doesn't use any materials
   b. might use them if you could find them
   c. has some materials available to use with selected patients
   d. has a supply of often used materials accessible in the clinic and knows how to access other video and written materials in the medical center

3. Assuming that your medical center has some group classes for patients such as smoking cessation or diabetes, your team
   a. never refers patients (What classes?)
   b. refers patients occasionally
   c. refers patients weekly
   d. discusses these referrals daily during appointment times with patients

4. Assuming that your medical center collects data on patient education as part of its quality improvement plan
   a. your team is unaware of this monitoring (What monitors?)
   b. your team learned about this process in a meeting or workshop
   c. your team has helped collect data
   d. your team uses collected data to improve patient teaching

5. Documentation of patient teaching
   a. is not regularly done
   b. is written in the progress note when it occurs
   c. is done on a multidisciplinary flow sheet
   d. includes an educational assessment in addition to interventions and evaluation of results

6. When the team is trying to meet the educational needs of challenging patients you
   a. follow-up with an appointment in six months.
   b. refer them to the library
   c. hold a team meeting to problem solve
   d. in addition to the team meeting seek advice of an education consultant

7. Primary care teams need to teach patients how to access care in the new system. Your team
   a. does not provide this information
   b. refers patients to materials in the waiting room
   c. has clerical support staff hand out pamphlets and answer questions during check-out
   d. provides patient education on this topic as a regular part of patient care.

8. Given a fund control point at your facility for patient teaching materials your team
   a. does not know about these resources
   b. has heard about resources for materials
   c. has acquired teaching materials in the past
   d. has a member that monitors acquisition of needed educational materials.

9. As part of daily interaction with patients your team
   a. does not provide health teaching about specific diseases—no time.
   b. answers questions that patients may have about chronic conditions.
   c. assesses patient knowledge of disease and teaches based on assessment
   d. in addition to individual assessment has ongoing teaching plans for frequent diseases.

10. This self assessment has
    a. been a waste of time
    b. stimulated discussion of possible changes in approach to patient teaching
    c. validated that the team is on track with teaching
    d. resulted in changes to the team approach to patient teaching.

BONUS QUESTION

Given the VA focus on prevention and health promotion, your team
   a. does not have time to talk with patients about prevention
   b. regularly answers patient questions about health promotion and disease prevention.
   c. regularly counsels patients about identified risk factors such as smoking
   d. Uses age, sex and risk specific guidelines to implement specific prevention counseling activities with the entire panel of patients.

SCORING for the Self-Discovery Quiz:

For each “a” circled give your team 0 point. For each “b” give your team 3 points. For each “c”credit your team with 7 points. For each “d” add 10 points. Total.

100-110 Points	Contribute an article to this newsletter.
88-100 Points	Your team is extraordinary. Keep up the excellent work!
70-87 Points	Your team is doing a good job integrating teaching into primary care. Keep up the good work!
40-69 Points	Your team has potential. Use this update to help your team expand their roles in health teaching.
0-39 Points	Your team has not put a priority on patient teaching. Let us know how we can help you to overcome barriers to effective teaching

SAMPLE TEMPLATE Central Texas Veterans Health Care System

PATIENT EDUCATION PROGRAM: CLINIC EXIT INTERVIEW AND INSTRUCTIONS

ASSESSMENT: Prior to teaching the veteran indicated readiness to learn*
INSTRUCTORS'S DOCUMENTATION OF PATIENT/FAMILYEDUCATION

Goal: Patient (significant other) will verbalize understanding of instructions for follow-up care.

Who was taught: ☒ Patient ☐ Significant Other

I. Review of Orders
A. On leaving the clinic, patient is to go to:
☐ Lab ☒ X-ray ☐ EKG ☐ Clerk ☐ Pharmacy
B. Follow-up appointments:

Code for Patient/Family Response:
1) Able to perform 2) Able to verbalize 3)Unable to perform
4) Unable to verbalize 5) Needs reinforcement 6) Not receptive

II. Education Topics Addressed	Patient Response:	Teaching Methods
A. Preps and Instructions		
☐ Barium Enema (Prep per Fleets prep kit)	2	☐ Demonstration
☐ Upper GI (NPO after midnight, Laxative after exam)	2	☒ Lecture ☒ Handouts ☐ Slides ☐ Video
☐ IVP		☐ Discussion
☐ Proctoscopy (Prep per DPP Instruction)		☐ Other_____
☐ Guiac—cards/instruction		
☐ Fasting Blood Work		
☐ 24 Hour Urine		
☐ Other _____		
B. Diet Reinforcement		
C. Med Change		
D. Disease Process	2,5	
E. Obtaining Further Treatment		
☐ 1-800 Phone Number and how to access clinic prn		
☐ ER Availability		

III. Referrals made:
☐ Smoking Cessation ☐ Diabetes Class ☐ Lipids Class
☐ Glucose Meter class ☐ PACT
☐ Hypertension Class ☒ Nutrition

IV. Comments: Wife apparently has questions; asked to come to next visit.

*This template wording can be changed if veteran is not ready to learn.

ELECTRONIC DOCUMENTATION

Continued from page 4

A <Patient Health Summary> has been established that pulls together ALL education templates that have been completed into one report. As with any Health Summary, a clinician can have these printed along with the encounter forms on all patients or for a particular patient. Thus if all clinicians document correctly, any other clinician should be able to see easily what the patient has been taught and his or her response to the teaching. Since one option to describe patient response is "needs reinforcement," a clinician seeing a patient for follow-up is able to see what needs to be reinforced. One exception was made—portions of the education requirements have been added to some of the physicians' regular templates. These are NOT captured in the Health Summary and have to be looked for individually.

There are multiple benefits of the electronic documentation system. First there is no question about meeting JCAHO standards. It is possible to identify which services are or are not doing patient education and it helps clinicians know what other disciplines have done. Additionally, this system contributes to improved continuity of care by enhancing communication among disciplines regarding an individual veteran's progress. Finally, record monitoring for patient health education is facilitated. There are problems, including the need for ongoing encouragement to help clinicians change long held behaviors regarding documentation. The current system also sometimes requires the creation of two notes to document the entire visit which is difficult for all disciplines and unacceptable for physicians.

There are also lessons learned that can guide others development of similar systems.

- Users need to be involved in the development of the templates. Even the order of information on the "page" can impact the clinician's routine.
- If at all possible, one person or a small team should oversee the template development. Otherwise templates may be set up incorrectly and not be picked up by the Health Summary. Others may not consistently meet institutional or JCAHO standards.
- There is a learning curve for those who have never used electronic documentation. For a while, people easily revert to old ways especially when the clinic is very busy. Everyone will need encouragement to continue using the templates until it becomes an acknowledged part of their practice.
- Software needs to be developed that can extract the patient education components of each clinician's progress note rather than the current situation where a nurse, for example, must create both a progress note and a patient education note.

Contact Nancy McKinney, RN, CDE, Patient Educator, Waco site, CTVHCS, COM 254/752-6581, Ext. 6933; FTS 700/734-6933.

NEW Feature: *Performance Improvement Training*

ENCOURAGING ADHERENCE TO MEDICAL RECOMMENDATIONS

Beginning with this issue, Patient Education and Primary Care will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit choose one of the following two options:

- ❑ Read the attached summary *"Encouraging Adherence to Medical Regimens,"* and write brief answers to the following questions. Turn these in to your supervisor along with this two page content description. OR
- ❑ Organize a one hour brown bag journal club or set aside time during a staff or team meeting to read the original article —*Miller, N.H. et al. (1997) The multilevel compliance challenge. Circulation. 95(4):1085-1090*—and discuss the following questions. Turn in a master list of journal club participants along with this two page content description.

See **NEW FEATURE,** *page 7*

NEW FEATURE

Continued from page 6

QUESTIONS:

1. What are the major barriers to adherence faced by the patient population served by my primary care team?
2. What counseling strategies, or practice changes could be used to overcome these barriers?
3. What are two actions I could take during the next month to improve adherence among my team ís veteran patients?

SUMMARY: The Multilevel Compliance Challenge[1]

Compliance or adherence to medical recommendations is a complex behavioral process strongly influenced by the environments in which patients live, health care providers practice and health care systems deliver care. Substantial evidence currently exists that many patients do not follow recommended medication, diet and other self-management behaviors. For example, it is estimated that one third or more of ambulatory patients take prescribed medication at intervals that are longer than prescribed—often hours, sometimes days, occasionally weeks. The American Heart Association convened an expert panel on compliance to review research related to this issue and make recommendations for practice as well as further research. The following paragraphs summarize the panel's recommendations for practice.

The majority of research on patient compliance has focused on identifying and minimizing barriers to compliance. While behaviors differ, in general, factors that appear to significantly influence compliance include the patient's knowledge, previous levels of compliance, confidence in ability to follow recommended behaviors, perception of health and benefits of therapy or behavior, availability of social support and complexity of the regimen. Some factors are affected by patient communication with the provider but patients must also have the motivation and skills to undertake a recommended behavior or treatment.

Enhancing a patient's motivation requires careful assessment of his or her readiness to make and maintain behavior changes. Building a patient's skills requires that he or she learn tasks such as reading food labels, selecting appropriate foods in restaurants, and incorporating taking medications into his or her daily routine. Thus patients must learn new strategies to help them adopt and maintain a new behavior, especially when daily routines are interrupted. Although these strategies may differ for different behaviors, certain skills are commonly required, such as problem solving, self-monitoring, developing prompts and reminder systems, identifying a potential relapse into an old behavior, enlisting social support, setting appropriate and realistic goals and rewarding achievement of new behaviors.

Moreover, multiple skills are often necessary for patients to comply with new behaviors and maintain them over time or to give up established unhealthy behaviors. Asking a patient to modify several lifestyle behaviors, especially for an asymptomatic condition such as hypertension further complicates the compliance challenge. Even with motivation and skills, patients still have difficulty complying. They need to incorporate self-reminders into their daily routine, and they need advice on how to adapt to changes in their schedules and environment.

To improve patient outcomes by decreasing nonadherence requires a commitment by patients health care providers, and organizations delivering care. Maximum use of already known strategies to increase adherence must be made. The solution to this challenge is not as simple as telling patients

[1]**The following information is summarized from the following journal article—Miller, E.H. et al. (1997) the multilevel compliance challenge: recommendations for a call to action. Circulation.95(4): 1085-1090.**

See **SUMMARY,** *page 8*

SUMMARY

Continued from page 7

what to do and then telling them again if the desired effect is not achieved. The literature supports a multilevel approach requiring educational, behavioral and policy strategies at the patient, provider and organizational levels.

For example, clinicians must provide clear, direct messages about the importance of a behavior or therapy. They should include patients in decisions about prevention and treatment goals using active listening, goal setting, negotiation and anticipation of barriers to compliance. They should provide opportunities for patients to develop self-monitoring and problem solving skills in order to address these barriers. Clinicians should also assess and document patients' progress toward adherence goals and develop reminder systems to ensure adequate follow-up.

Healthcare organizations must also develop an environment that supports these prevention and adherence strategies. For example, appropriate staff development must be provided to all team members so that they are comfortable with assessment of compliance, interactive counseling and other adherence enhancing strategies. Educational resources such as learning centers, educational materials, and group classes must be developed to support the time-limited one-to-one interventions that can be implemented during a clinic visit. Adaptions to clinic operations that will support adherence including use of preappointment reminders, telephone follow-up and evening/weekend office hours should be considered. Finally, systems to promote interdisciplinary access to electronic medical records and continued use of the quality improvement process to assess progress toward adherence goals are also critically important.

COMING IN APRIL—*A Closer Look at Elements of a Brief but Effective Counseling Session*

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.

Do you have any successful patient education strategies that you would like to share with us?

Contact Barbara Giloth (773/743-8206 or email bgilot1@uic.edu), Carol Maller (700/572-2400, ext 4656 or email maller.carol@albuquerque.va.gov) or Charlene Stokamer (700/662-4218 or email stokamer.charlene@new-york.va.gov) with your input!

Patient Health Education in Primary Care Task Force:

Dennis Cope, MD
ACOS Ambulatory Care
VAMC Charleston, SC

Barbara Giloth MPH, CHES
Program Planning Consultant
Chicago, IL

Linda Livingston, MSN, RN
Staff Nurse/Primary Care
VAMC Grand Junction, CO

Carol Maller, MSN, RN, CHES
Patient Health Education Coordinator
VAMC Albuquerque, NM

Nancy McKinney, RN, CDE
Patient Educator
Central Texas Veterans Health Care System, Waco, TX

Carolyn Stanley-Tilt, MSN, RNCS, FNP
Family Nurse Practitioner
VAMC Salem, VA

Charlene Stokamer, RN, MPH, CHES
Patient Health Education Coordinator
VAMC New York, NY

Office of Primary and Ambulatory Care

Employee Education System